

ELIGIBILITY
State of Oregon & APS Healthcare

Start of Process

State of OR updates OHP-FFS file every Tuesday & sends it as Care Coordination Program "Eligibility File" to APHS ("NLM start date")

"Eligibility File" is received by APHS weekly & loaded to C3 System *

State of OR updates OHP-FFS "Claims File" on 1st Tuesday following 2 complete weeks each month & sends it to APHS ("Outreach start date")

"Claims File" is received by APHS monthly & loaded to C3 System* as supplemental information

Compliance: NLM sent to address in eligibility file within 30 days of Eligibility date

All clients in Eligibility and Claims files are considered "Eligible Clients" and receive the "Nurse Advice Line Mailing" (NLM) unless they received it within the past 12 months.

Other Possible Inputs: Hospital Inpatient Census Reports, Care Net Referral, Phone call into Call Center, Referral from State or other source, Phase II Re-Perc.

Hospital Inpatient & Emergency Room Census Reports: Census information is received from hospitals throughout the State by specialized Care Coordinators via fax, secured web site, or secured email. If the client is not acuity 4 or 5, then, based on clinical discretion the optimum acuity level should be entered, with Level of Care listed as Full and status listed as Open. If client is acuity 4 or 5, they should be assigned to Community-Based Health Coach (RN), with status Open and Level of Care Full. Health Coach (RN) should follow up with Hospital to get discharge details and work plan for Transition of Care. If face-to-face contact is not required, then begin standard Outreach process telephonically. If required, then complete face-to-face contact with client at Clinic, Hospital, etc. and begin standard Outreach process.

Care Net Referral: Clients who call Care Net's Nurse Advice & Referral Line who require on-going intervention or care coordination are followed up by OHPCC staff members. A fax received the next day details the interaction. Based on the RN's discretion, OHPCC Staff member calls client to ensure their needs were met & inquire if they need further assistance.

Phone Calls into Call Center: The client is assisted immediately or transferred to another staff member who is able to assist. If unable to assist immediately, OHPCC staff will set an activity in the C3 System to call back.

Referral from State or Other Source: Referrals from the State, a PCP, or other sources are generally considered a high priority. They are assigned to the most appropriate OHPCC staff member based on services required. OHPCC Executive Director is kept informed (particularly on State referrals so proper follow up can be done. This may include flagging some as "Red Flag Cases" and reporting progress in the regular client meeting. OHPCC staff also give a progress report to the referring source from the State via phone or email as appropriate.

Phase II Re-Percolation of a Client: If client Perc to acuity 4, it will be reported on the monthly report. OHPCC staff will outreach to offer assistance to new acuity 4 clients (even if they have worked with them before).

Oregon Health Plan Care Coordination

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APS Healthcare is a subsidiary of KEPRO

ENROLLMENT
APS Healthcare & C3 System

* C3 System is APHS's client information management system for "Care Coordination"

Percolator System assigns acuity 0, 2, 3 or 4 based on health information received

Acuties 1 or 5 are only assigned by OHPCC staff members: 1 is for Partial; 5 is generally for hospitalized clients

All clients with acuties 1-5 are "Enrolled" & put on a list of Clients who need "Outreach." (See lists of Excluded FFS & Duals)

Compliance: Acuties are assigned monthly

Excluded FFS

Excluded Duals

OUTREACH
Telephonic: Manual & Automated (Televox)

Standard Outreach Process

Compliance: Outreach for acuity 1-3 must be done in 60 days; Outreach for acuity 4-5 must be done in 30 days.

The "Date of First Successful Contact" ("DOFSC") is a significant day in the workflow & compliance with the contract.

Outreach phone call attempt 1

Successful Contact? *

YES

NO

Outreach phone call attempt 2

Successful Contact? *

YES

NO

Outreach phone call attempt 3

Successful Contact? *

YES

NO

Compliance: Each of the 3 Outreach phone call attempts must be on different days & different times of the days

Compliance: HIPAA verification required in all staff interactions with clients

Difficult or "Unable to Reach" (UTR) clients

Engagement
Disease Management Coordinators

Program Introduction done for Client, with overview of OHPCC

Client Eligible?

NO

Status=Open; LOC=Low MODM; No assigned Health Coach; Acuity=Unchanged

MODM Status Reported to State

Clients remain eligible to call in & utilize services if their health conditions change

End

YES

Ask for Consent to Enroll

Full Consent Received?

YES

Enter consent in C3; Status is Open; LOC= Full

FFS: Collect Data on Assessment; Dual: Set Health Coach appointment

Assign a Health Coach based on Case Load

NO

Partial Consent Received?

YES

Enter partial consent in C3; Status=Open; LOC=Partial; Acuity=1; Unassigned

Assessment Desired? Optional

NO

Chart in notes if client declines assessment

YES

Close Episode; Reason "Opt Out" - Only acceptable "Opt Out" reasons are: Opt Out or Deceased

Send Opt-Out Letter

End

Client Reached?

YES

Keep Acuity = 4 or 5; Keep assigned; LOC: Low UTR

Set follow-up for 91-135 days post Acuity set date; Personal call made - not automated; Send UTR letter. Close Open Activities

Still 4 or 5?

YES

NO

Batch Process weekly to identify clients who had 3 unsuccessful contacts & send them "Unable to Reach" (UTR) letters.

UTR Letter Sent; Status=Open; LOC=Low UTR; Acuity=1; Un-assign

Phase II Re-Perc

If Perc to Acuity 4, then re-engage client with fresh outreach attempts

Applicable to new & existing clients

Acuity 4 or 5 requires more than just phone call attempts to client; If initial contact is unsuccessful, then staff must access other sources to seek contact, like MMIS, APD caseworker, pharmacies, primary care physicians, family members, POAs, discharge records, etc.

MANAGEMENT
Telephonic & Community Based Health Coach (RN)

**** Services provided to clients by OHPCC include:**

- Nurse Advice/Triage Line**-- designed to provide clinical support to clients at any time (24x7)
- Disease Management**-- focused on diabetes, asthma, CAD, CHF, COPD, depression & other diseases
- Case Management**-- focused on highest acuity clients based on current claims data, assessments & clinical interventions
- Patient-Centered Health & Wellness Interventions**-- to address all physical, mental & sociological needs, when possible.

RNs use discretion to identify clients whose acuity could be lowered due to improved health in order to balance case loads, prioritize & focus time & services on clients with higher acuties to maximize effectiveness & impact of services.

"SNA-BRA" means combined Social Needs Assessment & Behavioral Risks Assessment.

Compliance: Assessment must be done within 90 days of DOFSC & refreshed annually.

Complete SNA-BRA or Duals Assessment & Plan of Care (POC) within 90 days of DOFSC

Status: Open; LOC=Full; Acuity 1 to 5

Provide On-Going Services*, as Necessary

Check & document each day contact is made if Acuity Adjustment or POC change is needed?

Adjust Acuity &/or POC, as Required

Complete Disease Specific Assessments, if needed

One year mark passed?